		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030304

Facility Name: Four Fountains Convalescent Center

Address: 101 South Belt West (Number) Belleville (City) 62220 (Zip Code)

County: St. Clair

Telephone Number: (618) 277-7700 **Fax #** (618) 277-7363

IDPA ID Number: 371182089001

Date of Initial License for Current Owners: 11/4/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Wayne Franklin **Telephone Number:** (618) 624-2157

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants Compilation Report (Date)

(Print Name and Title) J. Wayne Franklin, Senior Manager

(Firm Name & Address) Blue & Company, LLC
125 Springfield Court, Suite #1, O'Fallon, IL 62269

(Telephone) (618) 624-2157 Fax # (618) 624-2159

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,756	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,756	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,062	485	2,546	4,093	8
9	SNF/PED					9
10	ICF	25,064	22,530	534	48,128	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,126	23,015	3,080	52,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.95%

D. How many bed-hold days during this year were paid by Public Aid? 239 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/4/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/4/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,504

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	207,779	36,277	22,249	266,305		266,305		266,305			1
2	Food Purchase		221,078		221,078		221,078		221,078			2
3	Housekeeping	143,177	26,697	451	170,325		170,325		170,325			3
4	Laundry	66,568	7,050	4,508	78,126		78,126		78,126			4
5	Heat and Other Utilities			120,079	120,079		120,079		120,079			5
6	Maintenance	55,094	25,702	15,648	96,444		96,444		96,444			6
7	Other (specify):*											7
8	**TOTAL General Services**	472,618	316,804	162,935	952,357		952,357		952,357			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,806,197	215,601	274,121	2,295,919	(113,299)	2,182,620		2,182,620			10
10a	Therapy	38,110		213,452	251,562	(54,269)	197,293		197,293			10a
11	Activities	56,091	6,391	116	62,598		62,598		62,598			11
12	Social Services	109,980	1,523	4,192	115,695		115,695		115,695			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,010,378	223,515	499,081	2,732,974	(167,568)	2,565,406		2,565,406			16
	C. General Administration											
17	Administrative	152,764		102,259	255,023		255,023		255,023			17
18	Directors Fees											18
19	Professional Services			67,086	67,086		67,086		67,086			19
20	Dues, Fees, Subscriptions & Promotions			47,796	47,796		47,796	(16,225)	31,571			20
21	Clerical & General Office Expenses	85,827	12,715	37,632	136,174		136,174	(1,734)	134,440			21
22	Employee Benefits & Payroll Taxes			428,987	428,987		428,987		428,987			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,126	8,126		8,126		8,126			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,216	56,216		56,216		56,216			26
27	Other (specify):* Contributions			105	105		105	(105)				27
28	**TOTAL General Administration**	238,591	12,715	748,207	999,513		999,513	(18,064)	981,449			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,721,587	553,034	1,410,223	4,684,844	(167,568)	4,517,276	(18,064)	4,499,212			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Line 43 Detail:

Physicians Visits	$830
Sales tax	$19,171
Total	**$20,001**

Facility Name & ID Number Four Fountains Convalescent Center #0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			292,674	292,674		292,674	1,089	293,763			30
31	Amortization of Pre-Op. & Org.			804	804		804		804			31
32	Interest			437,147	437,147		437,147	(3,182)	433,965			32
33	Real Estate Taxes			72,791	72,791		72,791	(5,881)	66,910			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,781	10,781		10,781		10,781			35
36	Other (specify):*											36
37	**TOTAL Ownership**			814,197	814,197		814,197	(7,974)	806,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,366	5,366	167,568	172,934		172,934			39
40	Barber and Beauty Shops	15,884	1,067	10,617	27,568		27,568		27,568			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,134	91,134		91,134		91,134			42
43	Other (specify):* see Attached			20,001	20,001		20,001	(19,171)	830			43
44	**TOTAL Special Cost Centers**	15,884	1,067	127,118	144,069	167,568	311,637	(19,171)	292,466			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,737,471	554,101	2,351,538	5,643,110		5,643,110	(45,209)	5,597,901			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,089	30		9
10	Interest and Other Investment Income	(3,182)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19,171)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(105)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,761)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,706)	20		28
29	Other-Attach Schedule Sch A	(13,373)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,209)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (45,209)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Medical Supplies	x		38,870	10-2	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		74,429	10-2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule Therapy	x		54,269	10a-3	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 167,568		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Four Fountains Convalescent Center

ID# 0033034

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,734)	21	1
2	Lobbying Cost PAC Dues	(797)	20	2
3	Chamber of Commerce Belleville	(475)	20	3
4	Public Relations	(4,486)	20	4
5	Non Care Property Tax	(5,881)	33	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(13,373)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,225)	0	0	0	0	0	0	0	0	0	0	(16,225)	20
21	Clerical & General Office Expenses	(1,734)	0	0	0	0	0	0	0	0	0	0	(1,734)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(105)	0	0	0	0	0	0	0	0	0	0	(105)	27
28	**TOTAL General Administration**	(18,064)	0	0	0	0	0	0	0	0	0	0	(18,064)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,064)	0	0	0	0	0	0	0	0	0	0	(18,064)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Four Fountains Convalescent Center** **#** **0030304** **Report Period Beginning:** **1/1/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,089	0	0	0	0	0	0	0	0	0	0	1,089	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,182)	0	0	0	0	0	0	0	0	0	0	(3,182)	32
33	Real Estate Taxes	(5,881)	0	0	0	0	0	0	0	0	0	0	(5,881)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,974)	0	0	0	0	0	0	0	0	0	0	(7,974)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(19,171)	0	0	0	0	0	0	0	0	0	0	(19,171)	43
44	**TOTAL Special Cost Centers**	(19,171)	0	0	0	0	0	0	0	0	0	0	(19,171)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,209)	0	0	0	0	0	0	0	0	0	0	(45,209)	45

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Four Fountains Associates	100.00	Columbia Convalescent Center	Columbia	None		
		Collinsville Care Center	Collinsville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Steven Brant	Manager	Administrative		78,180	40	80.00	Salary	$ 67,459	L17,C1	1
2	JoAnne Brant	Accountant	Accounting	0.00	250	As Needed		Acctg Fees	5,181	L19, C3	2
3	Tim Crowley	Director/President	Administrative		0	8	20.00	Owners Comp	102,259	L17,C3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 174,899		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization None
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	N/A									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters Bank		X	Mortgage	$52,506.50	04/01/00	$ 5,906,305	$ 5,710,288	2/14/04	0.0750	$ 437,147	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$52,506.50		$ 5,906,305	$ 5,710,288			$ 437,147	9
	B. Non-Facility Related*											
10				Interest Income							(3,182)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,182)	14
15	TOTALS (line 9+line14)						$ 5,906,305	$ 5,710,288			$ 433,965	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Four Fountains Convalescent Center **#** 0030304 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	72,791	2
3. Under or (over) accrual (line 2 minus line 1).	$	72,791	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	72,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	47,719	8
	1996	50,981	9
	1997	55,668	10
	1998	67,878	11
	1999	72,791	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,562 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 7,000 2. Number of Years Over Which it is Being Amortized: 9

3. Current Period Amortization: 804 4. Dates Incurred: 1985

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	218,250	1985	$ 585,985	1
2					2
3	TOTALS	218,250		$ 585,985	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144		1985	1972	$ 3,826,500	$ 127,550	30	$ 127,550	$	$ 1,847,025	4
5	22		1996	1996	840,066	25,825	30	25,825		122,244	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1986	23,852	795	30	795		11,527	9
10	Land Improvements			1991	3,947		15	263	263	2,499	10
11	Building Improvements			1987	10,614	354	30	354		4,779	11
12	Building Improvements			1988	11,664	389	30	389		4,862	12
13	Building Improvements			1989	192,108	6,404	30	6,404		72,075	13
14	Parking Lot Repavement			1989	20,043	1,336	15	1,336		15,364	14
15	Building Improvements			1990	42,771	1,426	30	1,426		14,974	15
16	Building Improvements			1991	30,378	1,013	30	1,013		10,130	16
17	Land Improvements			1991	1,127	75	15	75		750	17
18	Building Improvements			1992	11,841	790	30	790		6,628	18
19	Carpeting			1992	318	3	7	3		318	19
20	Land Improvements			1992	3,777	252	15	252		2,127	20
21	Building Improvements			1993	1,253	89	7	89		1,253	21
22	Land Improvements			1993	2,581	173	15	173		1,338	22
23	Building Improvements			1993	12,614	841	15	841		6,382	23
24	Building Improvements			1994	6,876	459	15	459		5,582	24
25	Building Improvements & Land Improvements			1994	40,120	4,014	10	4,014		22,695	25
26	Building Improvements			1995	16,869	1,125	15	1,125		6,518	26
27	Building Improvements			1995	33,390	3,340	10	3,340		19,069	27
28	Architect Fees			1996	65,004	2,167	30	2,167		21,781	28
29	Landscaping			1996	9,566	638	15	638		2,871	29
30	Parking Lot			1996	20,700	1,035	20	1,035		4,658	30
31	Roof			1996	77,643	3,882	20	3,882		17,469	31
32	Sprinkler System			1996	158,000	10,533	15	10,533		47,399	32
33	Wall Coverings			1996	64,986	9,284	7	9,284		41,778	33
34	HVAC/Electrical			1996	94,899	9,490	10	9,490		42,705	34
35	Title Recording Fee			1996	73,747	2,458	30	2,458		11,266	35
36	TOTAL (lines 4 thru 35)				$ 5,697,254	$ 215,740		$ 216,003	$ 263	$ 2,368,066	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Other Construction Costs			1996	106,285	2,717	30	3,543	826	15,944	9
10	Interior Signs, Pipe Line, Shower Dryers			1996	2,522	253	10	253		1,139	10
11	Alarm Systems			1996	6,242	625	10	625		2,813	11
12	Window Coverings			1996	14,905	2,981	5	2,981		13,415	12
13	Door, Fire Sprinklers			1996	1,226	82	15	82		369	13
14	Landscaping, Sewer Tap Fee			1996	12,443	830	15	830		3,838	14
15	Light Fixtures, Architect Fees (new wing), Plumbing			1996	18,986	633	30	633		2,849	15
16	Construction Period Interest			1996	25,143	1,676	15	1,676		7,542	16
17	Construction Change Orders			1996	2,254	225	10	225		1,013	17
18	Carpeting			1996	46,930	1,564	30	1,564		7,038	18
19	Hot Water Pipes			1997	1,303	130	10	130		412	19
20	Storage Shed			1997	1,002	100	10	100		375	20
21	Laundry Water Tank			1997	2,050	205	10	205		820	21
22	Remodeling			1998	2,090	139	15	139		313	22
23	Replace Asphalt			1998	8,525	853	10	853		1,777	23
24	Therapy Kitchen			1999	7,500	500	15	500		958	24
25	Roof			1999	112,353	7,490	15	7,490		13,108	25
26	Shower			1999	1,910	127	15	127		223	26
27	Therapy Kitchen			1999	2,802	187	15	187		296	27
28	Water Heater			1999	9,806	654	15	654		981	28
29	Safe Stride Slip Resistant Floor			1999	480	32	15	32		35	29
30	Asphalt			2000	2,765	81	20	81		81	30
31	Sign Lettering			2000	900	23	20	23		23	31
32	Fire Suppresion System			2000	2,259	206	15	206		206	32
33	Remodeling			2000	22,172	243	15	243		243	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 414,853	$ 22,556		$ 23,382	$ 826	$ 75,811	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 710,699	$ 52,335	$ 52,335	$		$ 312,411	37
38	Current Year Purchases	29,689	2,043	2,043			2,043	38
39	Fully Depreciated Assets	811,565					811,565	39
40								40
41	TOTALS	$ 1,551,953	$ 54,378	$ 54,378	$		$ 1,126,019	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,250,045	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 292,674	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 293,763	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 1,089	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,569,896	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	None	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$ None	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,781 Description: Dietary $5,127, Admin. $5,654
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	306	$ 20,207	$	306	$ 20,207	1
2	Licensed Speech and Language Development Therapist		hrs		191	12,621		191	12,621	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		304	21,441		304	21,441	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				74,429		74,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies Sold Other (specify): Lab,X-Ray,Amb					5,366	38,870		38,870 5,366	13
14	TOTAL			$	801	$ 59,635	$ 113,299	801	$ 172,934	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 158,126	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	520,194		3
4	Supply Inventory (priced at Cost)	35,778		4
5	Short-Term Investments			5
6	Prepaid Insurance	85,987		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	(3,933)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 796,152	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	585,985		13
14	Buildings, at Historical Cost	6,055,997		14
15	Leasehold Improvements, at Historical Cost	56,108		15
16	Equipment, at Historical Cost	1,551,955		16
17	Accumulated Depreciation (book methods)	(3,553,862)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Cost	526		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,696,709	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,492,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,564	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,143		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,825		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	19,947		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Other	110,903		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 485,382	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,710,288		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,710,288	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,195,670	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (702,809)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,492,861	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (662,447)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (662,447)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,637	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(125,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (40,362)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (702,809)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,238,297	1
2	Discounts and Allowances for all Levels	(73,898)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,164,399	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	297,495	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 297,495	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	31,406	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,643	17
18	Sale of Supplies to Non-Patients	58,305	18
19	Laboratory	28,703	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	705	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 230,762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,182	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,182	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Cost Report Settlements	30,175	28
28a	Miscellaneous	1,734	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,909	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,727,747	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	952,357	31
32	Health Care	2,732,974	32
33	General Administration	999,513	33
	B. Capital Expense		
34	Ownership	814,197	34
	C. Ancillary Expense		
35	Special Cost Centers	52,935	35
36	Provider Participation Fee	91,134	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,643,110	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,637	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,637	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,080	$ 48,403	$ 23.27	1
2	Assistant Director of Nursing	1,936	2,080	36,817	17.70	2
3	Registered Nurses	16,085	17,280	333,943	19.33	3
4	Licensed Practical Nurses	27,751	30,536	457,432	14.98	4
5	Nurse Aides & Orderlies	89,212	95,737	929,602	9.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,662	3,979	38,110	9.58	8
9	Activity Director	7,705	8,182	56,091	6.86	9
10	Activity Assistants					10
11	Social Service Workers	8,147	8,888	109,980	12.37	11
12	Dietician					12
13	Food Service Supervisor	2,309	2,735	32,817	12.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,880	24,240	174,962	7.22	15
16	Dishwashers					16
17	Maintenance Workers	4,188	4,395	55,094	12.54	17
18	Housekeepers	23,445	25,246	143,177	5.67	18
19	Laundry	8,086	8,624	66,568	7.72	19
20	Administrator	1,940	2,080	85,305	41.01	20
21	Assistant Administrator	1,443	1,668	51,574	30.92	21
22	Other Administrative					22
23	Office Manager	10,792	11,763	101,712	8.65	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,315	1,329	15,884	11.95	33
34	TOTAL (lines 1 - 33)	231,824	250,842	$ 2,737,471 *	$ 10.91	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	700	$ 18,194	1-3	35
36	Medical Director	150	7,200	9-3	36
37	Medical Records Consultant	10	330	10-3	37
38	Nurse Consultant	40	2,094	10-3	38
39	Pharmacist Consultant	96	720	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	116	11-3	44
45	Social Service Consultant	216	4,076	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,215	$ 32,730		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	4,609	126,190	10-3	51
52	Nurse Aides	9,119	139,864	10-3	52
53	TOTAL (lines 50 - 52)	13,728	$ 266,054		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steven Brant	Manger	2.3	$ 67,459
Hope McNitt	Administrator	0	85,305
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,764

B. Administrative - Other

Description	Amount
Tim Crowley	$ 102,259
TOTAL (agree to Schedule V, line 17, col. 3)	$ 102,259
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal	$ 10,535
Jennings, Jacknewitz & Schrader	Legal	2,292
Wessel & Pautsch	Legal	13,323
Lewis, Rice & Fingersh	Legal	105
Greensfelder, Hemker & Gale	Legal	231
Van Ostrand & Elvidge Kelly	Legal	2,712
RPG & Company	Accounting	16,750
Blue & Company, LLC	Accounting	5,175
JoAnne Brant	Accounting	5,181
Boyle, J. W. & Co.	Accounting	10,782
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 67,086

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,111
Unemployment Compensation Insurance	19,832
FICA Taxes	203,020
Employee Health Insurance	93,716
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	(80)
Other Benefits	17,029
Payroll Processing	8,359
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,987

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 495
Advertising: Employee Recruitment	22,669
Health Care Worker Background Check	
(Indicate # of checks performed 70)	854
Lobbying, Advertising & Public Relations	12,044
Yellow Pages	3,706
IHCA Dues	6,415
Chamber Dues	475
Publications	1,138
Less: Public Relations Expense	(4,486)
Non-allowable advertising	(8,033)
Yellow page advertising	(3,706)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	651
Seminar Expense	7,475
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,126

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	Not Applicable												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6415**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-30 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,044** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **91,134**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation. Costs to St. Louis within 50 miles
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Y**
Firm Name: **RBG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.